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No. 75-1447

In the Supreme Court of the United States

OCTOBER TERM, 1976

STEPHEN BERGER, individually and as COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES OF THE STATE OF NEW YORK, PETITIONER

v.

MARION AITCHISON, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

MEMORANDUM FOR THE UNITED STATES AS AMICUS CURIAE

ROBERT H. BORK,
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MEMORANDUM FOR THE UNITED STATES AS AMICUS CURIAE

This memorandum is submitted in response to the Court's invitation to the Solicitor General to file a brief expressing the views of the United States.

QUESTIONS PRESENTED

As part of its procedure for determining eligibility of the "medically needy" for participation in the program of Medical Assistance ("medicaid") established by Title XIX of the Social Security Act, 42

U.S.C. (and Supp. V) 1201 *et seq.*, the State of New York has established income exemption levels, for a large percentage of applicants, which are lower than the levels of payment standards it uses in its program of Aid to Families with Dependent Children under Title IV of the Act, 42 U.S.C. (and Supp. V) 601 *et seq.*

The United States will discuss the questions whether this aspect of New York's method of determining eligibility for and extent of medicaid assistance conflicts with regulations (45 C.F.R. 248.3(c)) of the Department of Health, Education, and Welfare under Title XIX of the Social Security Act and, if so, whether those regulations are consistent with the Act.

STATEMENT

1. Title XIX of the Social Security Act, 79 Stat. 343, as amended, 42 U.S.C. (and Supp. V) 1396 *et seq.*, creates a Medical Assistance program, commonly known as "medicaid," pursuant to which the states, with federal funds, may reimburse the costs of medical treatment provided to the "categorically needy," *i.e.*, those persons who receive payments under the cash assistance programs of the Social Security Act,[1]

[1] The present categorical assistance programs are the Aid to Families with Dependent Children (AFDC) program (Title IV of the Act, 42 U.S.C. (and Supp. V) 601 *et seq.*), the Supplemental Security Income (SSI) program (Title XVI of the Act, 42 U.S.C. (and Supp. V) 1381 *et seq.*), and (in Guam, Puerto Rico and the Virgin Islands) the programs of aid to the aged, blind, and disabled (Titles I, X, XIV, and XVI of the Act, 42 U.S.C. (and Supp. V) 301 *et seq.*, 1201 *et seq.*, 1351 *et seq.*, and 1381 *et seq.*).

and, if a participating state so chooses, to the "medically needy," *i.e.*, those individuals whose income and resources exceed the amounts allowed to the categorically needy but which are insufficient to cover the costs of necessary medical care and services. 42 U.S.C. (Supp. V) 1396a(a)(10)(A) and (C); 45 C.F.R. 248.1(a)(1) and (2).[2] If a state elects to extend medicaid coverage to the medically needy, its plan must include all individuals within that category and must offer each such person medical assistance equal in amount, duration and scope. 42 U.S.C. (Supp. V) 1396a(a)(10)(C)(i) and (ii). Thirty-two of the 54 jurisdictions participating in Title XIX, including New York (see N.Y. Social Services Law (N.Y.S.S.L.) 366(1) (McKinney 1976)), have chosen to extend medicaid coverage to the medically needy.

States offering medicaid coverage to the medically needy are accorded a range of discretion in fixing the amount of income an assisted family may retain to meet normal living expenses. To qualify for federal matching funds, the state may set that amount at not more than 133⅓ percent of the state's highest AFDC payment for a family of the same size without income or resources (42 U.S.C. 1396b(f)(1)(B)(i)), and at not less than "the higher of the levels of the payment standards generally used as a meas-

[2] See *Fullington* v. *Shea*, 320 F. Supp. 500 (D. Colo.), affirmed, 404 U.S. 963; *Freeman* v. *Parham*, 475 F.2d 185, 187 (C.A. 5).

ure of financial eligibility in the [categorical assistance] programs." 45 C.F.R. 248.3(c)(1)(ii).[3]

2. New York utilizes a two-step process to calculate the standard of need under its AFDC program:[4] for each recipient of categorical assistance under Title IV, the state includes (a) a flat amount, varying only according to family size, to cover all basic subsistence needs except shelter, and (b) a separate "shelter allowance." N.Y.S.S.L. 131-a(2); 18 N.Y.C.R.R. 352.3(a). The shelter allowance is determined by including the family's actual shelter costs up to a specified maximum amount for each of the State's 58 social services districts (Pet. 15; Pet. App. 9a-10a).

For the medically needy, however, New York computes medicaid eligibility in a different manner. As with the categorically needy, medicaid eligibility for these families is in part determined by reference to

[3] All parties agree that the relevant categorical assistance program in this case is the AFDC program. See Pet. 9, 15-16; Br. in Opp. 6; Pet. App. 9a, 19a, n.23.

[4] Although the states are required to establish "standards of need" under their AFDC program, these standards may be above the amounts actually paid. See *Rosado* v. *Wyman*, 397 U.S. 397, 408-409. Since it is a state's actual payment level for the categorically needy that determines the medicaid minimum income eligibility level for the medically needy (42 U.S.C. (Supp. V) 1396a(a)(10)(A)), 45 C.F.R. 248.3(c)(1)(ii) refers to "payment standards" rather than "standards of need." In any event, because New York pays AFDC benefits equal to 100 percent of its standard of need, the State's AFDC standard of need and payment standards are the same (Pet. App. 19a, n. 24). See N.Y.S.S.L. 131-a(2) and (3).

the basic flat grant payable to an AFDC family of the same size. But instead of adding to this amount a shelter expense equal to the family's actual rent (up to a maximum depending on locality), New York includes a uniform shelter allowance, calculated by averaging the shelter allowances paid to all AFDC families of comparable size throughout the State (Pet. 15-16; Pet. App. 5a-6a). N.Y.S.S.L. 366(2)(a)(8). Thus, except for the few medically needy families whose actual rent equals the statewide hypothetical shelter cost of an average AFDC family of comparable size, New York's method of determining medicaid eligibility ensures a discrepancy between the amount of maintenance income which a medically needy family is allowed to retain and the amount the family would be paid under the AFDC program if it were without any income.

3. Respondents are the wife and child of a disabled 54-year-old man who has been in a nursing home since 1972 (Pet. App. 4a). Their monthly income is $368.39 (Pet. 8). As a family of two,[5] under New York's method of determining medicaid eligibility they are entitled to assistance only after contributing $51.39 monthly toward the cost of George Aitchison's nursing home care, thereby reducing the amount of income available for their living expenses to $3,800 annually, or $317 monthly.

[5] For purposes of determining family size for medicaid eligibility, New York regulations provide that a family member in chronic care "shall not be deemed to be a member of any household" (Pet. App. 16a, n. 8). 18 N.Y.C.R.R. 360.5(e).

N.Y.S.S.L. 366(2)(a)(8). Under New York law, however, the monthly standard of need for an AFDC family of comparable size, paying the same rent and living in the same county as respondents, would be $370—the $150 basic subsistence allowance (N.Y. S.S.L. 131-a(2)) plus respondents' actual rent ($250) up to the specified ceiling of $220 for Rockland County (Pet. App. 5a). If the amount they could retain for themselves had been set at $370 per month, respondents would have been entitled to participate in the medicaid program without making a contribution to the cost of the nursing home care.

In March 1975, respondents instituted this action for declaratory and injunctive relief in the United States District Court for the Southern District of New York, contending that New York's statutes and regulations for determining minimum income levels for medicaid eligibility by the medically needy were in conflict with the Equal Protection Clause of the Fourteenth Amendment, Title XIX of the Social Security Act, and federal regulations under the medicaid program.

The district court certified the suit as a class action [6] and, pursuant to this Court's directions in *Hagans* v. *Lavine*, 415 U.S. 528, 543-545, addressed

[6] The district court defined the class represented by respondents as "all medically needy persons in New York who are required by [petitioner], pursuant to state statute and regulations, to live on a monthly income allowance which is below the level of need for categorical assistance families of the same size, living in the same county, and paying the same rent" (Pet. App. 7a).

respondents' statutory contentions before considering whether a three-judge district court was required to pass upon the constitutional claims. The court then held that New York's method of using *average* statewide shelter costs in fixing minimum income levels for medicaid eligibility by the medically needy, while at the same time using a family's *actual* shelter costs in setting AFDC standards of need, allowed the medically needy income eligibility level in certain cases to be set below the highest "payment standards generally used" in the State's categorical assistance program, in violation of 45 C.F.R. 248.3(c)(1)(ii) (404 F. Supp. 1137; Pet. App. 3a-21a). The court also held that the federal regulation was consistent with Title XIX, since it furthered the legislative goal of helping individuals not receiving general cash assistance cope with catastrophic medical expenses without having to impoverish themselves below the level of the categorically needy. N.Y.S.S.L. 366(2)(a)(8) and its implementing regulations were therefore declared invalid and petitioner was enjoined from enforcing them against respondents (Pet. App. 23a-25a). See *King* v. *Smith*, 392 U.S. 309, 333, n. 34. The court of appeals affirmed on the opinion of the district court (Pet. App. 1a-2a).[7]

DISCUSSION

The principal question presented in this case is whether New York may use a maximum income re-

[7] On April 19, 1976, this Court declined to stay the court of appeals' judgment pending a petition for a writ of certiorari.

tention level for medicaid recipients that may be significantly less than "the higher of the levels of the payment standards generally used as a measure of financial eligibility [for categorical assistance]." 45 C.F.R. 248.3(c)(1)(ii). In our view, the district court correctly determined that New York is precluded from utilizing a maximum income retention level which is based on an average shelter allowance when the State's relevant categorical assistance payment standard is based on a family's actual shelter costs, which often exceed the average allowance. Because of the disparity in the State's standards for the categorically and medically needy, respondents are required to contribute to the payment of health costs even though their protected income maintenance level may be lower than that of recipients of categorical assistance—a result that is at odds with the legislative intent of Title XIX. See 42 U.S.C. (Supp. V) 1396a(a)(10)(C) and (a)(17). Since the result reached below is correct and is in accord with the decisions of other courts, and since few if any other state medicaid plans suffer the defect found in New York, this case presents no issue warranting review.

1. From the inception of the Medical Assistance program in 1965, Congress has recognized that a large segment of the American people are not qualified for or in need of general or "categorical" assistance to meet their day-to-day expenses but nonetheless require financial aid because of substantial medical burdens. In defining the "medically needy" for purposes of medicaid eligibility, Congress characterized

the group as "less needy" than recipients of categorical assistance (S. Rep. No. 404, pt. I, 89th Cong., 1st Sess. 77 (1965)) and included "all individuals who would, except for income and resources, be eligible for [categorical assistance] * * * and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services * * *." 42 U.S.C. (Supp. V) 1396a(a)(10)(C)(i).

The language and legislative history of Title XIX evidence an unmistakable congressional intent not to require the medically needy to reduce their level of maintenance income below their state's categorical assistance standard of need as a precondition to medicaid relief. Indeed, the purpose of assistance to the medically needy is to help the working poor *avoid* the necessity of living below a subsistence level because of heavy medical bills. As the Senate Finance Committee stated in recommending adoption of the "spend-down" provision in Title XIX,[8] which allows an in-

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[8] 42 U.S.C. (Supp. V) 1396a(a)(17) provides in part that a state plan must

> provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law * * *.

After all appropriate factors have been subtracted, an applicant's income is measured against the participating state's medically needy minimum income level. Those whose count-

dividual to qualify for medicaid coverage if the deduction of his incurred medical expenses would reduce his income to the medically needy level (S. Rep. No. 404, *supra*, at 79):

> In no event * * * may a State require the use of income or resources which would bring the individual's income below the amount established as the test of eligibility under the State plan. Such action would reduce the individual below the level determined by the State as necessary for his maintenance.

These concerns are implemented by 45 C.F.R. 248.3(c)(1)(ii), which requires state medicaid plans to set the minimum amount that the medically needy may retain for normal living expenses at a figure equal to or above the most liberal payment standard generally used in the state's categorical assistance programs.[9] Compliance with the Secretary's directive

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able income is below the medically needy level are automatically eligible for medicaid assistance. Those with countable income above the medically needy level must "spend-down" to establish eligibility, *i.e.*, they must incur medical expenses in an amount equal to their excess income. 45 C.F.R. 248.3(c)(2); 45 C.F.R. 248.4(b)(5). Any additional medical expenses are absorbed by medicaid.

[9] This regulation was initially published by the Secretary in the *Handbook of Public Assistance Administration* § D-4220(A)(1)(b) prior to its promulgation in 1969. The *Handbook* stated:

> The income levels for maintenance must be, as a minimum, at the level of the most liberal money payment standard used by the State, at any time on or after January 1, 1966, as a measure of financial eligibility in any categorical money payment program in the State.

thus assures that a state may not insist that a medically needy individual "spend-down" below the level which the state has deemed necessary for subsistence, and hence—in contravention of the express congressional assumption—become more needy than the categorically needy in order to receive aid under Title XIX.

2. The district court correctly concluded that the method adopted by New York for determining eligibility for and extent of medicaid assistance violates the federal regulation.[10] Those medically needy individuals in New York, such as respondents, whose actual shelter costs are within the AFDC maximum shelter allowance for the social services district in which they live but are above the average statewide shelter allowance for a family of comparable size, are required to "spend-down" below the level of support furnished persons through AFDC categorical assistance. This is the precise evil against which 45 C.F.R. 248.3(c)(1)(ii) is directed.

Respondents' case clearly illustrates the defect in the New York practice. Marion Aitchison and her daughter Janice receive a monthly income of $368.39, primarily from social security disability benefits (Pet. 8). Since respondents' income exceeds the $317 level of N.Y.S.S.L. 366(2)(a)(8), they must "spend-down" the overage, $51.39 per month, before the

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[10] Although the Secretary originally approved New York's medicaid plan, he has now advised the State that its average shelter cost provisions are not in compliance with 45 C.F.R. 248.3(c) and Title XIX of the Act. See App. A, *infra*.

New York medicaid program will defray the medical expenses occasioned by George Aitchison's nursing home care. If respondents were totally without income or resources, however, they would receive a monthly subsistence payment of $370 under New York's AFDC program (see p. 6, *supra*), in addition to full medicaid coverage under 42 U.S.C. (Supp. V) 1396a(a)(10)(A), and would accordingly retain more income.

None of the reasons offered by petitioner justifies this anomolous result. The phrase "generally used" in 45 C.F.R. 248.3(c)(1)(ii) cannot support the use of an artificial "average" shelter cost since, as the district court correctly observed (Pet. App. 12a), "New York's 'average ADC standard' is never used, let alone generally used, as the ADC payment standard." The more reasonable interpretation of that phrase is that a participating state is obliged only to set its medically needy eligibility level no lower than the highest categorical assistance payment that the state would make in otherwise similar cases, but without taking into consideration unusual special need items such as, *e.g.*, corrective shoes. See, *e.g.*, N.Y.S.S.L. 131-a(6).

Nor is there merit to petitioner's related contention (Pet. 21) that New York has no single AFDC standard of need and that, therefore, any reasonable minimum maintenance level that it selects for the medically needy would fulfill the requirements of 45 C.F.R. 248.3(c)(1)(ii). The State's AFDC payment standard consists of the basic flat grant plus the variable

component attributable to the applicant's *actual* shelter cost (up to a maximum based on locality). Although this of course produces different AFDC assistance payments in disparate cases, it does not follow that the State cannot fix a readily ascertainable payment standard except by resort to a statewide average. See Br. in Opp. 11-17; App. A, *infra*. By nonetheless adopting an average shelter cost, New York's plan is patently unreasonable because it necessarily withholds medicaid assistance from a substantial number of applicants until they become more needy than recipients of categorical assistance.

Finally, New York's use of an average shelter cost is not sanctioned by the approval given by this Court and the Secretary to flat grants on the basis of the consolidation of previously variable items (Pet. 16, 25-28). See *Rosado* v. *Wyman*, *supra*, 397 U.S. at 419. As the Court noted in *Shea* v. *Vialpando*, 416 U.S. 251, 265, n. 13, "*Rosado* * * * was in no sense intended as a blanket approval of the principle of averaging under AFDC programs without regard to what is being averaged." The departmental materials on which petitioner relies (Pet. App. 30a-43a) refer only to categorical aid programs such as AFDC, in which a limited flat-grant concept may be feasible, rather than to wholly different programs such as medicaid. But more importantly, petitioner's arguments are simply inapposite: federal medicaid regulations do not disallow reliance on averaging under all circumstances; rather, they require only that when a state uses actual costs in computing standards of

need for its categorical assistance programs, it must incorporate comparable standards in determining income eligibility for the medically needy, lest some medically needy individuals be forced to "spend-down" below the level determined necessary for subsistence.[11]

3. Although respondents contend (Br. in Opp. 11-17) that the problem of substantially disparate medicaid and categorical assistance levels is "virtually unique" to New York, the Secretary believes that a few other states may derive their medically needy eligibility standards by averaging certain variable items that are paid on an actual cost basis in the categorical assistance grant. In either event, the problem illustrated by this case is not extensive and can be handled administratively by the Secretary through negotiation with participating states or, if necessary, disapproval of state plans. See 42 U.S.C. 1396a(b).[12]

Furthermore, the decision of the district court is consistent with the holdings of other courts [13]—includ-

[11] As the letter from the Department's Acting Regional Commissioner (App. A, *infra*) indicates, the Secretary believes that income eligibility for the medically needy need not be determined on an individualized basis and that all that Title XIX requires is the establishment of firm, rational standards against which all individuals' eligibility may be tested and which fulfill the purposes of the Act.

[12] In May 1975, for example, the Secretary advised the Boston Regional Commissioner that a Connecticut plan to average shelter costs in determining eligibility would violate federal medicaid regulations. See App. B, *infra*.

[13] See *Dominguez* v. *Milliken*, CCH Medicare and Medicaid Guide ¶ 26,633 (W.D. Mich.); cf. *Schaak* v. *Schmidt*, 344 F. Supp. 99 (E.D. Wisc.); *Wilczynski* v. *Harder*, 323 F. Supp. 509 (D. Conn.); *Wong* v. *Brian*, CCH Medicare and Medicaid Guide ¶ 26,605 (Cal. Ct. App.).

ing a New York state court ruling that concerned the precise statute involved here. *Schlemowitz* v. *Lavine*, 75 Misc. 2d 529, 347 N.Y.S. 2d 133 (Sup. Ct.). In these circumstances, we believe that further review of this case is not required.

CONCLUSION

It is respectfully submitted that the petition for a writ of certiorari should be denied.

ROBERT H. BORK,
Solicitor General.

WILLIAM H. TAFT, IV,
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SARAH WILLIS WILCOX,
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Department of Health,
Education, and Welfare.

SEPTEMBER 1976.

APPENDIX A

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REGION II
FEDERAL BUILDING
26 Federal Plaza
New York, New York 10007

Social and Rehabilitation Service

Jul. 19, 1976

Mr. Philip L. Toia
Commissioner
New York State Department
of Social Services
1450 Western Avenue
Albany, New York 12243

Dear Mr. Toia:

After extensive consideration, we have concluded that the medically needy levels contained in your Title XIX plan raise serious questions of compliance with Federal requirements. This letter discusses the basis for our questions and the steps required to remedy the problem.

The federal regulations at 45 CFR 248.3 (c) provide, in part, that with respect to the medically needy:

> The income levels . . . must be, as a minimum, at the higher of the levels of the payment standard generally used as a measure of financial eligibility in the money payment programs, that is:

(A) In the case of families of three or more, at the level of the payment standard of the state plan approved under title IV-A generally applied;

(B) In the case of individuals, or families . . . of two persons, at the higher of:

(1) The payment standard . . . under title IV-A generally applied, or
(2) The highest level of payment which is generally available to individuals in any of the three groups (aged, blind, and disabled) who are (or would be, except for income) eligible for benefits under title XIX;".

This regulation means in general that the lowest medically needy eligibility level must be at the highest cash welfare standard for the comparable family or individual. The intent of the regulation is twofold and reflects the statutory mandate of sections 1902 (a) (10) and 1902 (a) (17) of the Act. First, as provided in section 1902 (a) (10) of the Act, the medically needy, (if the state wants to cover that group), must include all those individuals who "but for income and resources" would be categorically needy Medicaid recipients. In most instances, the categorically needy are cash assistance recipients. Therefore, the medically needy standard must be such that people with income sufficient to bar them from cash assistance do not have to become "poorer" than cash recipients before becoming eligible for Medicaid. It follows that if the level is below the amount used

for cash assistance, a family might be required to "spend-down" to an amount lower than the payment to a welfare family without income.

Furthermore, section 1902 (a) (17) requires that eligibility must be based on "reasonable standards" comparable for all groups, (of different size) and such standards cannot otherwise vary with respect to income levels except for the medically needy and then only based on a limited number of rural-urban differences.

Your Aid to Families With Dependent Children program incorporates various shelter allowances—up to a maximum—in determining eligibility for, and amount of, cash assistance under that program. That is, financial eligibility is determined by measuring an individual or family's available income against a basic payment standard plus a money amount up to a maximum representing shelter costs. At this point, a separate schedule of maximums has been established for each Social Services District.

The key question is how these various shelter standards must be treated in setting a medically needy eligibility level. As we understand it, the medically needy levels now in effect reflect an average of shelter payments, plus the standard for basic needs for each group. However, this system resulted in a disadvantage to certain people whose shelter costs were above the average, yet lived in an area where the shelter maximum was higher than this average.

As a consequence, the U. S. District court, in Aitchison v. Berger, found the "averaging" method invalid.

We have considered carefully the possibility that eligibility for the medically needy be determined on a case-by-case basis, using the applicable shelter maximum and the rent actually paid. The Medicaid recipient would be expected to "spend down" to the individually determined figure. Such a system, however, would not only be costly in terms of administrative time and expense, but would be in conflict with the Act and Regulations, in that section 1902 (a) (17) of the Act and 45 CFR 248.3 contemplate a statewide simplified medically needy standard for groups of comparable size with the only exception being urban-rural variations.

We must conclude, therefore, that, given the present AFDC standard, compliance with Federal statute and Regulations could best be achieved by establishing a limited number of medically needy levels based on groupings of the shelter variations by Social Service District. The medically needy level for each group or cluster of Social Service Districts would be the basic payment standard, plus the *highest* shelter maximum in each cluster.

We recognize that such an action would materially increase medically needy levels at a point when you are confronted by serious fiscal restraints. However, this alternative would satisfy the requirements of the Act and the implementing Regulations.

Since the currently effective medically needy levels are contained in the approved New York Title XIX plan, we are now withdrawing our approval of that section of the State plan. The standards in question are contained in Attachment 2.6-A of the approved plan, submitted by Transmittal 74-2 and approved on December 30, 1974. If it is not possible for your agency to take corrective action, it will then be necessary for us to recommend to the Secretary that this section of the State plan be disapproved.

Our staff is of course available at any time to discuss the matter further.

Sincerely yours,

/s/ William Toby
WILLIAM TOBY
Acting Regional Commissioner

APPENDIX B

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
Office of the Administrator

Date: May 29, 1975

TO : Mr. Neil Fallon
SRS Regional Commissioner
Region I—Boston

FROM : Administrator
Social and Rehabilitation Service

SUBJECT: Connecticut—Medicaid Eligibility—Medically Needy Income Levels
(Your memoranda of 6/18/74, 10/1/74 and 10/11/74)

This is in response to your memoranda requesting information on the extent to which a State may vary its medically needy income levels on the basis of urban-rural differentials in shelter costs.

a. Is the State required to establish more than one medically needy income level to reflect variations in shelter costs?

No. Per Section 1902(a)(17), in determining eligibility, a State must include reasonable standards which must be comparable for all groups. In determining reasonable standards

for the medically needy, the State is not required to reflect the variation in shelter costs between urban and rural areas.

b. How many income levels to reflect urban-rural variations in shelter costs may the State have?

A State may apply a variation based on an urban-rural distinction in shelter costs thus establishing two income levels. However, if a State can establish that more than two urban-rural variations in shelter costs exist, additional variations could be approved under the plan.

c. If a State has three variations in AFDC standards, but retains a single income level for the medically needy, how is the amount of single income level determined? That is, must the single income level be set at the highest amount paid under the AFDC program in any area of the State?

Since the AFDC shelter amount is as paid, up to a maximum, can the State use an averaging method, means or median, in determining the shelter costs that go into the standard?

If the State has in effect three approved variations in AFDC standards, and if the State wishes to establish one medically needy income level, the State must set its single medically needy income level at least at the highest of the three AFDC standards (conforming, of

course, to other regulations on the establishment of the medically needy level (45 CFR 248.3(c)(1)(i), (iii) and 248.4(b)(4)). In no case could the State use an averaging method to set its medically-needy level.

/s/ James S. Dwight, Jr.
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